Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELIZABETH A KUMMER, MD
P.O. BOX 741865
DALLAS, TX 75374

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3569-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requester did receive the above mentioned checks. However, as shown by the EOB's provided by the Respondent, the check for $630.56 was for bill #39789 for $700.00 which was for an FCE. The checks for $750.00 & $19.44 have been applied to the DDE which leaves a balance of $480.46. This Respondent continually brings up invoices not related to the MDR case's at hand. It would save time for all parties involved if proper research was done by the Respondent before bringing up payments made to unrelated bills."

Amount in Dispute: $480.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines Please see attached EOBs."

Response Submitted by: New Hampshire c/o Flahive, Ogden & Latson, P.O. Box 201329, Austin, Texas 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 29, 2010	99456-WP-W5	$480.56	$480.56

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated January 16, 2011
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated March 3, 2011
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated (not legible)
   18 – DUPLICATE CLAIM/SERVICE

Issues

1. Has the Designated Doctor (DD) Maximum Medical Improvement/Impairment Rating (MMI/IR) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of $650.00 for CPT code 99456-WP-W5 for a DD Examination. Review of the documentation supports that the doctor assigned MMI. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00 Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the lumbosacral (spinal region) is $150.00. The combined MMI/IR MAR is $500.00.
2. The respondent has paid $19.44 for CPT code 99456-WP-W5, therefore an additional $480.56 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $480.56.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $480.56 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.